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Clinical review

ABC of mental health: Common mental health problems in hospital

Amanda Ramirez, Allan House

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Introduction

The prevalence of mental health problems in patients attending acute general hospitals is high. The three main types of clinical problem are

- Acute primary psychiatric disorder, including deliberate self harm and other psychiatric crises and emergencies
- Psychiatric disorder in patients with physical illness
- Psychologically based physical syndromes (somatisation).

Prevalence of mental health problems in general hospitals

- Hospital attendances for deliberate self harm average 150-200 per 100 000 population. A district general hospital with a population of 250 000 will have about 500 attendees a year. In central London 11% of acute adult medical admissions follow deliberate self harm
- Up to 5% of patients attending accident and emergency departments have only psychiatric symptoms, 20-30% have important psychiatric symptoms coexisting with physical disorder
- Patients with serious physical illness have at least twice the rate of psychiatric disorder found in the general population: 20-40% of all hospital outpatients and inpatients have an important psychiatric disorder
- A quarter of new outpatients to a medical clinic have no important relevant physical disease: 9-12% of referrals of medical outpatients may involve somatisation

All doctors have a role in addressing the mental health needs of their patients. However, the mental health problems of general hospital patients are closely tied to their physical illness, and specialist units (such as cancer, renal, pain, neurology, or AIDS services) may experience a high level of psychiatric disorder. Patients, and staff, benefit from specific psychiatric liaison support to facilitate integration of their psychological and physical care.

Key features of a liaison psychiatry service

- Fully integrated multidisciplinary team including liaison psychiatrists, clinical psychologists, psychiatric nurses, and social workers, with special skills in the use of psychological and social interventions
- Based within the general hospital and easily accessible to all departments
- Collaboration with other psychiatric services, social services, and non-statutory services to provide follow up for patients whose continuing needs for care are best met by community services
- Provides a rapid response to immediate problems and emergencies such as deliberate self harm

Features of a service for specialist units

- Initial assessments of patients undertaken jointly by a physician and psychiatrist or clinical psychologist. A model for this approach is the multidisciplinary pain clinic
- Conducts dedicated outpatient clinics alongside the acute specialty clinics
- Provides input to regular psychosocial meetings within specialist units
- Conducts outpatient groups for anxiety and stress management and problems of adjustment to illness

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Acute primary psychiatric disorder

Deliberate self harm

About 100 000 cases of deliberate self harm present to accident and emergency departments annually in the United Kingdom. Most acts of deliberate self harm involve self poisoning, and nearly half of these



involve paracetamol overdose. About 12% of patients injure themselves in other ways, usually by cutting. Alcohol consumption forms a part of about 45% of episodes of deliberate self harm.

Among patients attending hospital with deliberate self harm, the two sexes are currently equally represented and the average age is about 30 years. For most, the act is a response to social and interpersonal problems such as housing or work related problems, unemployment, debt, and conflicts in relationships. Only a minority have severe mental illness.

About 15% of patients attend hospital again within a year of harming themselves and at least 1% commit suicide. In England and Wales about 1000 patients who have deliberately harmed themselves commit suicide each year—almost a quarter of the total annual suicides. The Health of the Nation's target on reducing suicide could be met entirely by halving the suicide rate after hospital attendance for deliberate self harm.

Managing deliberate self harm—Integrated management of such patients is facilitated by overnight admission to an accident and emergency short stay ward, even when this is not medically indicated. This provides the opportunity for adequate psychosocial assessment, including family involvement in the process, and temporary respite from the precipitating crisis. Some patients may, of course, decline admission but should be assessed as fully as possible before they leave hospital.

Features of a service to manage deliberate self harm

- Brief admission available to all as an option
- Early psychosocial assessment by specially trained and supervised staff after initial medical management
- Immediate access to psychiatric care where appropriate
- Early follow up by multidisciplinary team, with outreach or domiciliary visits when necessary
- Good communication and liaison with medical and surgical teams, general practitioners, and other agencies

Risk groups for deliberate self harm

Patients at high risk

- Those with psychiatric disorder, including

Major affective disorder

Substance misuse

Schizophrenia

- But they constitute only a small proportion of cases

Patients at lower risk

- Those with social and personal problems who are dysfunctional problem solvers due to

Lack of support

Previous abuse or neglect

- They constitute a large proportion of cases

Assessing deliberate self harm—All patients presenting with deliberate self harm benefit from a psychosocial assessment by staff specifically trained for this task. This is in agreement with the Department of Health's recommendations for good practice. The assessment has two functions. Firstly, the sizeable minority of patients who have a psychiatric disorder (usually mood disorder or clinically important substance misuse) can be identified. These patients benefit from standard psychiatric treatment.

Therapy based on problem solving

This includes teaching patients to

- Identify problems and arrange priorities for problem solving
- Generate a wide range of solutions
- Narrow this down to concrete and attainable goals that would represent a personally important improvement
- Work out and implement steps to achieving goals, together with ways of determining and maintaining success

Secondly, it provides an opportunity to understand a patient's predicament in a way that integrates symptoms and mental state with information about social and interpersonal difficulties. Full assessment of the context in which an individual episode has occurred improves accurate diagnosis and reduces the pejorative use of diagnostic terms such as "personality disorder."

Intervention after deliberate self harm is intended to improve the social adjustment and personal wellbeing of patients and may reduce the risk of repetition. Brief individual therapy based on a problem solving approach is of most value.

Other psychiatric crises and emergencies

Accident and emergency departments of acute general hospitals are commonly the first port of call for people in crisis. The use of an accident and emergency department by psychiatric patients depends on the organisation of acute general psychiatry services. The proportion of attendees with psychiatric problems is greatly increased if the accident and emergency department is a "place of safety" to which the police may bring a person who seems to be suffering from mental disorder under the Mental Health Act 1983. Many types of acute psychiatric problem may present to an accident and emergency department or occur among inpatients on the wards.

Types of acute psychiatric problem that may present in hospitals

- Acute psychiatric disturbance (such as paranoid states, mania, delirium, panic)
- Alcohol and drug misuse, including delirium tremens
- Problems of adjustment to chronic physical illness, especially to repeated hospital admission (such as for asthma or epilepsy)
- Mood disorder (such as anxiety states, depression)
- Personal crises

Identifying psychiatric disorder in physically ill patients

Physical illness with high risk of psychiatric disorder

- Severe, life threatening disease
- Painful, stressful, or disfiguring treatment

Unexplained poor outcome of physical illness

- Poor compliance
- Excessive handicap
- Multiple symptoms or presentations

Patients with high risk of psychiatric disorder

- Previous psychiatric history
- Poor social support

Concurrent psychological symptoms

- Worries

- Anxiety symptoms
- Depressive symptoms

Managing psychiatric crises and emergencies—Assessment of these patients is similar to the approach outlined for patients with deliberate self harm. This can be undertaken effectively by a psychiatric nurse, who coordinates subsequent care with the relevant agencies, including the liaison psychiatrist, general psychiatric services, and social services.

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Psychiatric disorder associated with physical illness

Psychological problems that may be associated with physical illness

- Poor compliance with advice or treatment (such as for diabetes, asthma, sickle cell disease)
- Unexplained handicap, when functional disability after an acute illness is out of proportion to physical impairment
- Sexual dysfunction, which may result from a complex interplay of several factors (emotional impact of the illness, general debility, metabolic and hormonal changes, autonomic and arterial disease, and side effects of prescribed drugs)
- Body image disorders after mutilating surgery (such as colostomy, limb amputation, mastectomy, surgery for head and neck cancer)
- Eating disorders, including anorexia and bulimia nervosa, and obesity (such as in diabetics)

Psychiatric disorder may be a consequence of physical illness (such as mood disorder in cancer patients), a cause (such as pancreatitis in patients with alcohol misuse), or a coincidental occurrence. Less than half of the psychiatric disorder in physically ill patients is recognised and treated appropriately.

Mood disorder is mainly anxiety and depression in association with life threatening illness, chronic disability, or hospitalisation. Two thirds of mood disorders tend to resolve as part of the normal process

of adjustment to physical illness. A third do not improve unless specifically addressed and so require active treatment.

Alcohol and drug related problems—Alcohol contributes indirectly to many conditions that present to acute general hospitals, particularly gastrointestinal, liver, and neurological disorders. Drug related problems include hepatitis, infective endocarditis, and HIV infection.

Mental disorder may be associated with brain disease (such as stroke, head injury, and epilepsy).

Other psychological problems that may be associated with physical illness include poor compliance with advice or treatment, unexplained handicap, sexual dysfunction, body image disorders, and eating disorders.

Basic psychological skills for all clinicians

All hospital doctors should be able to

- Communicate clearly with patients, discuss concerns, and elicit misapprehensions and correct them
- Break bad news
- Facilitate grieving by patients and their relatives
- Discuss psychological symptoms and distress without embarrassment
- Discuss the need for specialist psychiatric help without seeming dismissive
- Use antidepressants rationally

Management strategies for all patients with physical illness

All doctors can act to minimise psychological distress in their patients by

- Identifying worries and concerns (whether accurate or inaccurate)
- Providing factual information and educating patients about their illness and its management
- Encouraging appropriate expression of anxiety and distress
- Reviewing patients to identify any persistent worries and mood symptoms
- Referring patients with persistent psychological difficulties to mental health services.

Treatments for psychiatric disorder in physically ill patients

Brief psychological treatments delivered by trained staff are effective and include grief work, cognitive-behaviour therapy, behaviour therapy, and interpersonal psychotherapy

Non-specific "counselling" and "support" are of limited benefit in managing clinically

important psychological problems

Antidepressant drugs are beneficial in patients with conspicuous mood disorder. Tricyclic antidepressants and selective serotonin reuptake inhibitors have similar efficacy but different toxicity profiles. The choice of drug should take account of patients' physical symptoms (for example, tricyclics may benefit those with pain and insomnia but should be avoided in patients with prostatism)

Treating psychiatric disorder in physically ill patients

The cornerstone of treatment is psychological therapy, either alone or in conjunction with psychotropic drugs. In practice the available treatments are not exclusive and can be modified according to the needs of each patient. For example, in some patients undergoing cognitive-behaviour therapy, an intrusive marital problem may emerge that requires the introduction of marital or family therapy. Psychiatrists must be alert to the development or progression of organic disease and collaborate with the medical team in developing a management strategy.

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Psychologically based physical syndromes (somatisation)

Many patients referred to hospital for investigation of physical symptoms do not have an identifiable physical disorder that explains their symptoms. About a quarter of new cases of abdominal pain in gastroenterology clinics and atypical chest pain in cardiology clinics and most general practice referrals to neurology have no relevant physical disease. Many of these patients do not respond to reassurance and, if discharged, are referred to another department or another hospital. Most of these patients have psychological factors underlying their illness.

Management strategies for patients with unexplained physical symptoms

It is important that

- Patients' symptoms and their understanding of these symptoms are elicited in full
- Psychosocial cues are identified and explored (such as low mood, distressing events, and personal difficulties)
- Symptoms and investigations are reviewed—Telling patients that "nothing is wrong" is not helpful, but negative findings and their implications should be

discussed (for example, "There is no evidence that your symptoms are due to cancer")

- Clinicians then explain to patients that their physical symptoms may have a psychological origin (for example, tension headaches, hyperventilation, and tachycardia may all be manifestations of anxiety). This can be linked to current psychosocial problems that have been elicited
- Management plans can then be reviewed with patients, and limits set on further investigations and drug prescribing
- Revised plans are communicated to the patients' general practitioner to avoid misunderstandings and "doctor shopping"
- Referral to mental health services is considered.

Somatisation—the presentation of psychosocial distress as physical complaints—has costs to the patients, their relatives, and the health service, particularly in severe and chronic cases. It is associated with a burden of physical and psychosocial disabilities for patients and their relatives. It is costly in terms of unnecessary investigation and treatment, loss of income, iatrogenic problems, and unnecessary welfare benefits.

Psychological treatment of unexplained physical symptoms

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There are several psychological approaches to treating unexplained physical symptoms; the better evaluated are based on the principles of cognitive-behaviour therapy.

Clinical characteristics may have a bearing on the particular type of psychological treatment used. For example, markedly abnormal behaviour (such as staying in bed all day) indicates that behavioural treatment might be appropriate (such as graded activity). Cognitive treatment might be better suited to

patients with dysfunctional beliefs such as "Investigations should be able to find the cause of my symptoms" or "It is unsafe to do anything on my own."



Notes

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